

## ÉDITORIAL

# Renforcer les systèmes de données pour promouvoir la santé et les droits sexuels et reproductifs en Afrique subsaharienne

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Le développement de la santé et des droits sexuels et reproductifs (SDSR) en Afrique subsaharienne est fondamentalement entravé par la « pauvreté des données de santé »<sup>1</sup>. Si de nombreux pays à revenu élevé ont réalisé des progrès significatifs dans le renforcement de leurs systèmes de données de santé, l'Afrique subsaharienne continue de faire face à d'importantes lacunes<sup>1-3</sup>. Malgré le besoin crucial de pratiques fondées sur des données probantes, le paysage régional des données est caractérisé par une méconnaissance généralisée de la valeur intrinsèque de données exactes. De nombreux pays de la région ne disposent pas de recensements de population réguliers, de dossiers de santé fiables ni de systèmes fonctionnels d'état civil et de statistiques vitales.

L'exactitude des données est souvent compromise par une réticence profondément ancrée des populations à fournir des informations personnelles. Dans de nombreux contextes africains, les tabous culturels, les croyances religieuses et la méfiance envers les « étrangers » entraînent des taux de refus élevés lors des enquêtes menées auprès des ménages et dans les établissements de santé. Par exemple, une étude menée en Afrique du Sud a mis en évidence comment des femmes peuvent refuser de parler de santé reproductive en raison d'une opposition religieuse ou par crainte d'être jugées par les chercheurs<sup>4</sup>. Les données sont parfois sujettes à la falsification et au biais de désirabilité sociale. Les personnes interrogées « apprennent » souvent à répondre de manière à minimiser la longueur des questionnaires, par exemple en déclarant moins de partenaires sexuels pour éviter les questions complémentaires.<sup>5</sup>

Plus grave encore, la crainte de répercussions juridiques ou sociales conduit à la dissimulation active d'informations sensibles par les individus et les établissements de santé. Des personnes ont déclaré avoir menti sur leur statut sérologique ou sur les violences sexistes qu'elles ont subies par crainte d'une intervention policière ou de la stigmatisation sociale.<sup>4</sup>

Même lorsque des données sont disponibles, on observe une minimisation et une non-utilisation systématiques des informations factuelles pertinentes pour la prise de décision et la planification stratégique. L'institutionnalisation du suivi fondé sur les données demeure faible et les plans annuels sont souvent élaborés sans tenir compte des informations sanitaires courantes.<sup>6</sup> Dans de nombreux cas, la planification fondée sur des données probantes est supplantée par l'ingérence politique et le népotisme, où les intérêts politiques — plutôt que les données empiriques — déterminent quels programmes de santé sont mis en œuvre et qui est nommé pour les diriger.<sup>7</sup> Sans s'attaquer à ces barrières culturelles et structurelles, les systèmes de données continueront de produire des informations de mauvaise qualité qui ne permettront pas d'améliorer significativement les résultats en matière de santé sexuelle et reproductive dans la région.<sup>1,8</sup>

Depuis la Conférence internationale sur la population et le développement (CIPD) du Caire en 1994 et jusqu'aux Objectifs de développement durable (ODD) pour 2030, la santé sexuelle et reproductive est reconnue comme un droit humain fondamental.<sup>9-11</sup> Ce droit est désormais inscrit dans les politiques nationales de santé et les cadres juridiques de nombreux pays.

Le droit à la santé sexuelle et reproductive comprend l'accès à la contraception, aux soins de fertilité et d'infertilité, aux services de santé maternelle et périnatale, à la prévention et au traitement des infections sexuellement transmissibles, à la protection contre les violences sexuelles et sexistes, et à l'éducation à des relations saines et sans risque.<sup>12</sup> comprend également le droit à l'information et la capacité de faire des choix éclairés concernant sa vie reproductive.

Lorsque cet accès est retardé ou refusé, les conséquences peuvent être graves, notamment le décès, un handicap permanent et des difficultés socio-économiques. Pour que ces droits se concrétisent, les systèmes de santé ont besoin de systèmes de données robustes. Des données précises, actualisées et

## ORIGINAL RESEARCH ARTICLE

# Navigating motherhood twice: Lived experiences of teenage mothers with repeat pregnancies in a rural Municipality, South Africa

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## Abstract

Repeat adolescent pregnancy remains a significant public health concern in South Africa, particularly in rural settings. This study explored the lived experiences of young mothers with repeat pregnancies attending Ngangelizwe Community Health Centre in the King Sabata Dalindyebo Municipality, Eastern Cape. Twenty in-depth interviews were conducted with mothers aged 18–24 who experienced their first pregnancy during adolescence. Findings indicate that most repeat pregnancies were unplanned and shaped by delayed pregnancy recognition, limited support, and complex family and partner dynamics. Participants described challenges related to education, childcare, stigma, and access to youth-friendly healthcare services. Despite these challenges, young mothers demonstrated resilience and employed various coping strategies to manage the emotional, social, and financial pressures they faced. Strengthening family, school, healthcare, and community support systems is essential to enhance the well-being of adolescents navigating repeat pregnancies in rural South Africa (*Afr J Reprod Health* 2026; 30 [12]: 48-53).

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**Keywords :** Repeat adolescent pregnancy; young mothers; rural South Africa; resilience; youth-friendly healthcare

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## Résumé

Les grossesses répétées chez les adolescentes constituent un problème de santé publique majeur en Afrique du Sud, particulièrement en milieu rural. Cette étude a exploré le vécu de jeunes mères confrontées à des grossesses répétées et suivies au Centre de santé communautaire de Ngangelizwe, dans la municipalité de King Sabata Dalindyebo, province du Cap-Oriental. Vingt entretiens approfondis ont été menés auprès de mères âgées de 18 à 24 ans ayant connu leur première grossesse à l'adolescence. Les résultats indiquent que la plupart de ces grossesses répétées étaient non planifiées et influencées par un diagnostic tardif, un soutien limité et des dynamiques familiales et conjugales complexes. Les participantes ont décrit les difficultés liées à l'éducation, à la garde d'enfants, à la stigmatisation et à l'accès à des services de santé adaptés aux jeunes. Malgré ces obstacles, ces jeunes mères ont fait preuve de résilience et ont mis en œuvre diverses stratégies d'adaptation pour gérer les pressions émotionnelles, sociales et financières auxquelles elles étaient confrontées. Le renforcement des systèmes de soutien familiaux, scolaires, sanitaires et communautaires est essentiel pour améliorer le bien-être des adolescentes confrontées à des grossesses répétées en Afrique du Sud rurale (*Afr J Reprod Health* 2026; 30 [12]:48-53).

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**Mots-clés:** Grossesse répétée chez les adolescentes ; jeunes mères ; Afrique du Sud rurale ; résilience ; soins de santé adaptés aux jeunes

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## Introduction

Adolescent childbearing and rapid repeat pregnancies remain a significant public health concern globally, particularly in low- and middle-income countries. Although adolescent birth rates have declined over the past two decades, repeat pregnancies continue to account for a substantial proportion of adolescent fertility. In 2017, more than half (54%) of non-first adolescent births in low- and middle-income countries occurred within

23 months of a prior birth, highlighting the persistence of rapid repeat adolescent pregnancies.<sup>1,2</sup> Such closely spaced pregnancies are associated with elevated maternal and infant morbidity, disrupted education, and long-term socioeconomic disadvantages.<sup>1,3</sup>

In sub-Saharan Africa, repeat adolescent pregnancy remains a pressing public health issue, reflecting structural inequalities, constrained reproductive autonomy, gendered power relations, and limited access to adolescent-responsive sexual

and reproductive health services. A pooled analysis of 31 African countries reported a repeat-pregnancy prevalence of 12.84% among adolescent girls and young women, with marked variation across countries.<sup>5,6</sup> These patterns underscore the need for context-specific reproductive health interventions that move beyond individual-level explanations.

In South Africa, repeat adolescent pregnancy remains a critical concern, particularly in rural and socioeconomically marginalised settings. Although national data are limited, available studies suggest that approximately 17–20% of adolescent mothers experience a second pregnancy within two years.<sup>3,5</sup> In deep rural areas such as the Eastern Cape, including King Sabata Dalindyebo Local Municipality, systematic documentation of repeat adolescent pregnancy is sparse.<sup>7,10</sup> This gap highlights the importance of examining how adolescent mothers experience and navigate successive pregnancies within their everyday social, familial, and institutional environments.

This study explores the lived experiences of adolescent mothers with repeat pregnancies in a rural South African municipality, with particular attention to family and partner relationships, social expectations, and interactions with health and social services.

## Methods

### *Study design and setting*

This qualitative study explored the lived experiences of adolescent mothers with repeat pregnancies. The study was conducted at Ngangelizwe Community Health Centre in King Sabata Dalindyebo Local Municipality, Eastern Cape Province, South Africa. The municipality is predominantly rural and characterised by high unemployment, widespread poverty, and constrained access to adolescent-responsive sexual and reproductive health services.

### *Study population and sampling*

The study population comprised African adolescent mothers aged 18–24 years who had experienced a first pregnancy during adolescence and at least one subsequent pregnancy. Purposive sampling was employed to recruit participants likely to provide

rich and relevant insights into repeat adolescent pregnancy. Recruitment occurred through routine postnatal and child health services at the facility.

Eligibility criteria included: (1) experiencing a first pregnancy before the age of 20; (2) having had at least one subsequent pregnancy; (3) being aged 18–24 years at the time of interview; and (4) willingness and ability to provide informed consent. Interviews were conducted until thematic saturation was reached, consistent with qualitative research guidelines.<sup>12,13</sup> A total of 20 participants were interviewed.

### *Participant characteristics*

Table 1 summarises participants' socio-demographic characteristics and provides context for interpreting the findings. Participants were young women navigating early motherhood within contexts of economic hardship, educational disruption, and unstable partner relationships. These characteristics reflect the broader structural conditions within which repeat adolescent pregnancy occurs in the study setting.

### *Data collection*

Data were collected through semi-structured, in-depth interviews conducted in isiXhosa or English. Interviews lasted approximately 40–60 minutes and were conducted in a private room at the health facility to ensure confidentiality. An interview guide was used flexibly to explore experiences of first and repeat pregnancy, contraceptive knowledge and use, partner and family relationships, interactions with healthcare services, emotional responses, and coping strategies. All interviews were audio-recorded with participants' consent.

### *Data management and analysis*

Interviews were transcribed verbatim and translated into English where necessary. Transcripts were anonymised and stored securely. Data were analysed inductively using qualitative content analysis principles, involving repeated reading of transcripts, open coding, categorisation, and theme development.<sup>15,16</sup> Analysis focused on identifying patterns of meaning across participants' accounts

while remaining attentive to social and structural context.

### ***Ethical considerations***

Ethical approval was obtained from the University of KwaZulu-Natal Bio-Medical Research Ethics Committee (Approval No. BREC/0000/5335; approved 30 August 2023). Written informed consent was obtained from all participants. Participation was voluntary, and confidentiality and anonymity were maintained throughout the study.<sup>14</sup>

## **Results**

The findings illustrate how adolescent mothers experienced repeat pregnancies within contexts shaped by delayed pregnancy recognition, family reactions, interactions with healthcare services, emotional distress, and economic strain. Participants' accounts highlight both vulnerability and resilience as they navigated repeated motherhood.

### ***Delayed recognition of pregnancy***

Delayed recognition of pregnancy was common among participants and often left young mothers unprepared for the emotional and practical demands of motherhood. Several participants reported only becoming aware of their pregnancy months later, frequently after physical changes were noticed by family members.

*"I did not plan the first one because I only found out after 4 months. It was my sister who suspected my pregnancy and told me to go for a check-up, and then I was declared pregnant" (P12, 24 years old).*

In some cases, delayed recognition intersected with experiences of coercion and family disbelief, resulting in heightened vulnerability.

*"My big brother forced himself on me. My pregnancy was not planned. My family chased me away from home because they did not believe me. I decided to stay in a shack on my own. It is hard" (P5, 21 years old).*

### ***Family reactions to a repeat teenage pregnancy***

Family reactions to repeat pregnancies varied, ranging from support to rejection and conflict.

Several participants described strained relationships with family members, which in some cases led to school discontinuation or exclusion from the household.

*"I had a fallout with my uncle... and I had to drop out of school" (P7).*

Other participants reported receiving practical and financial support that helped them manage childcare responsibilities, despite disappointment expressed by family members.

*"They supported me financially, since social grant money was not enough. My mother would pay for day-care" (P13).*

### ***Interactions with healthcare providers***

Participants' experiences with healthcare services played an important role in shaping their engagement with care. Supportive and respectful healthcare workers encouraged young mothers to seek guidance and return for services, particularly regarding contraception and childcare.

*"At the clinic, they supported me. They were very nice and calm, motivated me, and advised me on contraceptives after pregnancy" (P18, 24 years old).*

However, some participants reported judgmental attitudes from healthcare providers, which discouraged consistent clinic attendance.

*"Sometimes they speak to you in a way that makes you feel ashamed, so I avoid going back to the clinic" (P7).*

### ***Selective disclosure and communication patterns***

Selective disclosure of pregnancy was common among participants. Many young mothers preferred to confide in peers or partners while avoiding conversations with parents due to fear of judgment or reprimand.

*"I can only share my thoughts with my friends and partner, but not with my parents" (P12).*

### ***Emotional distress and social pressures***

Repeat pregnancies were associated with significant emotional distress, including fear,

**Table 1:** Socio-demographic characteristics of interview participants (n = 20)

Characteristic	Description
Age range	18–24 years
Age at first pregnancy	All participants experienced their first pregnancy during adolescence (before age 20).
Number of living children	Most participants had two children; a small number had three.
Educational status	The majority had not completed secondary schooling; a few had returned intermittently after childbirth.
Employment status	Predominantly unemployed; a small number engaged in informal or casual work.
Living arrangements	Most lived with parents or extended family members.
Relationship status	The majority reported unstable or non-cohabiting relationships with the father(s) of their children.
Source of financial support	Primarily, family support and child support grants
Health service utilization	All participants had accessed public health services during pregnancy or postnatal care.

shame, and anxiety. Some participants described experiencing severe psychological strain following a subsequent pregnancy.

*“At one point, I wanted to commit suicide” (P2).*

Social scrutiny from family and community members further intensified these emotional challenges, contributing to isolation and reduced well-being.

### ***Educational and financial challenges***

Participants described how repeat pregnancies disrupted schooling and intensified financial hardship. Caring for multiple children limited opportunities for education and income generation, increasing dependence on family support and social grants.

*“After my first child, I was overwhelmed by financial responsibilities, but I had to find work and use social grants to support my children” (P6).*

### ***Coping strategies and sources of support***

Despite the challenges associated with repeat pregnancies, participants demonstrated resilience by drawing on multiple coping strategies. These included seeking informal employment, relying on social grants, accessing counselling services, and mobilising support from family members when available.

## **Discussion**

This study demonstrates that repeat adolescent pregnancy in a rural South African setting unfolds

within intersecting individual, relational, and structural constraints rather than as a result of individual behaviour alone.<sup>1,5,6</sup> By centering adolescents’ lived experiences, the findings reveal how reproductive decision-making is shaped by fear, stigma, disrupted schooling, constrained autonomy, and uneven support from families, partners, and health services. Participants’ accounts show that delayed pregnancy recognition was closely linked to fear of disclosure, anticipated judgment, and emotional distress.<sup>5,19</sup> These experiences limited timely engagement with healthcare services and complicated educational decision-making. Rather than reflecting a lack of awareness, delayed recognition appeared to be shaped by constrained reproductive self-efficacy within socially restrictive environments.

Educational disruption emerged as a critical pathway through which vulnerability to repeat pregnancy was reinforced.<sup>11,17</sup> Participants described how the interruption of schooling following a first pregnancy, combined with stigma and childcare responsibilities, narrowed future opportunities and increased dependence on intimate partners. School disengagement removed a key protective structure that had previously provided routine, access to information, and future orientation.

Family and community responses to repeat pregnancy played complex and ambivalent roles.<sup>17,18,20</sup> While some adolescents benefited from emotional or practical support, others experienced moral judgement and control that undermined autonomy and discouraged help-seeking. These

findings highlight how social environments can simultaneously offer protection and impose restrictions, shaping adolescents' reproductive experiences in contradictory ways. Healthcare encounters were central to adolescents' efforts to prevent subsequent pregnancies.<sup>4,8</sup> Supportive, respectful interactions with healthcare providers strengthened confidence and encouraged continued service use, while judgmental encounters reinforced stigma and avoidance.

These findings underscore the importance of youth-friendly, non-judgmental reproductive health services in supporting adolescents' reproductive intentions. Across participants' narratives, behaviour change emerged as fragile and contingent.<sup>18,19</sup> Adolescents identified both enabling conditions, such as supportive providers and open parental communication, and persistent constraints, including stigma, partner opposition, and limited-service responsiveness. Together, these experiences illustrate how adolescents' agency was constrained by social and structural conditions that limited their capacity to act consistently on preventive intentions.

Overall, the findings suggest that repeat adolescent pregnancy may reflect constrained agency rather than individual failure.<sup>5,18,19</sup> Adolescents' reproductive decisions were shaped through ongoing negotiations of motherhood, education, relationships, and healthcare access within unequal social environments. Addressing repeat adolescent pregnancy, therefore, requires interventions that extend beyond individual behaviour change to address the relational and structural contexts shaping adolescents' reproductive lives. These findings highlight the need for youth-friendly reproductive health services, school-retention support, and multi-level interventions that address stigma, relational dynamics, and structural barriers in rural settings.

### **Strengths and limitations**

A key strength of this study lies in its qualitative focus on adolescents' lived experiences within a rural setting that remains under-represented in the literature. By foregrounding participants' narratives, the study provides contextually grounded insight into the social and relational

processes shaping repeat adolescent pregnancy. However, the facility-based sample may exclude adolescents who are disengaged from health services, limiting the transferability of findings to other contexts.

In conclusion, repeated adolescent pregnancy in rural South Africa reflects complex relational and structural conditions rather than individual failure. Despite significant vulnerabilities, adolescent mothers demonstrate resilience and agency. Interventions must extend beyond behaviour-focused approaches to include youth-friendly healthcare, family and community engagement, parenting support, and structural initiatives addressing education and social welfare.

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